CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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GENERAL INFORMATION AND COVERED SERVICES

Freedom of Choice

Medicaid eligible individuals must be offered the choice of service provider(s). The individual's choice of providers is a federal requirement. Freedom of choice must be documented in the individual file of the recipient.

In addition to their freedom of choice of service providers, recipients continue to have a choice regarding where services are offered. Those choices consist of either the home or clinic setting.

General Information

This chapter describes the home health services available under the Commonwealth of Virginia's *State Plan for Medical Assistance* (Medicaid). Home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy individuals determined to be eligible for assistance. Home health services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided recipients not receiving state and/or federal assistance for those home health services covered by Virginia Medicaid.

For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting.

MEDALLION

MEDALLION is a mandatory primary care case management program that enables Medicaid recipients to select their personal primary care physician (PCP) who will be responsible for providing and/or coordinating the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. The PCP's name and telephone number are listed on the recipient's MEDALLION identification card. Please refer to the MEDALLION section of this manual for further details on the program.

Covered Services

Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a recipient in his or her place of residence. A recipient's place of residence does not include a hospital or nursing facility. Home health services are intended to provide skilled intervention with an emphasis on recipient/caregiver teaching. Home health services are not intended to provide long-term maintenance care.

Home health services must be prescribed by a recipient's attending physician and are part of a written plan of care that the physician reviews, signs, and dates at least every 60 days.

If the recipient is enrolled in MEDALLION, the physician must be the MEDALLION primary care physician (PCP).

If a specialist admits the recipient to home health, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

The home health agency must record the referral number at the time of intake or receipt of the request for services.

The following are covered home health services:

- nursing services;
- home health aide services;
- physical therapy services;
- occupational therapy services; and
- speech therapy services.

Medicaid mandates the use of the Outcome and Assessment Information Set (OASIS) for Medicaid recipients receiving skilled services. Medicaid will reimburse at the initial assessment visit rate when the recipient is admitted into home health services. If the need for skilled services is recertified or there is a need to reassess for changes in the care plan, Medicaid will reimburse at the follow-up visit rate. Recertification is required at least every 60 days. Some examples of reassessment for changes in the care plan may be, but not limited to are: new orders for a recipient who has been hospitalized or changes in the frequency of visits needed to perform the skilled services. The reimbursement rates for home health services are located in Appendix B of this manual.

All services furnished by a home health agency, whether provided directly by the agency's qualified staff or under contractual arrangements with others, must be furnished or under the supervision of qualified personnel as required by Part 484 of Title 42 of the *Code of Federal Regulations* and professional licensing requirements as required by the *Code of Virginia*.

HOME HEALTH SERVICES CRITERIA

The following is a description of the circumstances defining recipient eligibility for compensable home health services. First, the recipient's Medicaid eligibility card must show that coverage is effective at the time home health services are rendered. For more details regarding recipient eligibility, see Chapter III.

There must be a medical necessity for home health services, e.g., visits must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to establish a program to restore functions which have been lost or reduced by illness or injury.

A provider cannot bill a recipient for services if reimbursement is denied due to the provider's failure to obtain preauthorization or to perform other required administrative functions (i.e., obtain the required physician orders or dates on the home health plan of care).

Effective July 1, 2003, recipients may receive up to five (5) home health nursing, physical therapy, occupational therapy, or speech therapy visits annually without preauthorization. These limits include therapy services provided by home health and outpatient rehabilitation providers. Extensions to the five visits may be granted if the visits are medically necessary and are approved by the DMAS preauthorization contractor. Home health aide visits are limited to 32 per year with no provision for extensions.

Limits apply per recipient, regardless of the number of providers rendering the services. Annually means from July 1 of one year through June 30 of the following year. The home health agency must document that it has advised each recipient or responsible party of visit limitations at the time of admission to the home health program. Providers may contact the DMAS Provider Helpline at 1-800-552-8627 to obtain the number of remaining visits for a recipient for the year.

PREAUTORIZATION PROCESS AND DOCUMENTATION REQUIRED

Except when Medicare is the primary payor, when more that five visits are medically necessary, the provider must request preauthorization. When a recipient has Medicare Part B coverage, preauthorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

A request for a retrospective review may be submitted through U. S. Mail or fax to:

WVMI
6802 Paragon Place
Suite 410
Richmond, VA 23230
Fax: 1-800-243-2770 (All other areas)
Fax: 804-648-6880 (Richmond area)

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service.

The following information is required in order to determine if the individual meets criteria: (1) a physician order and nursing plan of treatment or therapy evaluation; (2) verification of medical necessity for the service; and (3) evidence of discharge planning. Preauthorizations are specific to the recipient, provider, service code, and specific dates of service. If a claim for a service requiring preauthorization does not match the authorization, the claim will be pended for review or denied.

Subsequent Recertification Review

Prior to the end of the last authorized date, or the next visit, the provider must submit the plan of treatment for continued preauthorization. This plan of treatment will be reviewed to determine if it meets DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the physician's signature and date on the plan of treatment. The DMAS preauthorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the preauthorization contractor will authorize a specific number of units and dates of service based on the plan of treatment.

Methods to Obtain PreAuthorization

Telephonic Preauthorization

To make a Telephonic preauthorization request, the provider must contact the DMAS preauthorization contractor, WVMI. The provider should be prepared to relate the physician's order for care and the treatement planned to the WVMI review analyst. The provider may be required to fax specific documentation. Telephonic preauthorization requests must be made directly to the DMAS preauthorization contractor at the following telephone numbers:

(804) 648-3159	Richmond Area
(800) 299-9864	All Other Areas

Except for comprehensive nursing visits, home health providers have the option of initiating preauthorization requests telephonically, via facsmile or on paper via the DMAS-351 Process. There may be circumstances when the provider will be required to submit written documentation in order to obtain preauthorization.

Facsimile Preauthorization

Requests for preauthorization may be submitted via facsimile using the WVMI fax sheet or the new DMAS-351 (6/03 revision). Refer to the Exhibits section at the end of this chapter for a sample of this form and the instructions. The provider must attach the required documentation as described above. If the request is approved, the preauthorization

contractor will authorize a specific number of units and dates of service. Effective July 1, 2003, the revised version of the DMAS-351 form may be obtained on the DMAS website, www.dmas.state.va.us.

DMAS-351 Process

For comprehensive skilled nursing visits, and any other visits the provider chooses to submit on paper, the DMAS-351 form (6/03 revision) must be utilized to request services that exceed specified program limits. (See "Exhibits" at the end of this chapter for a copy of this form and instructions for completion.) The PA Service Type for Home Health services is 0500 and is a required field on the DMAS-351 for proper processing. All preauthorization requests for retroactive eligibility must be submitted using the 6/03 revision of the DMAS-351. The completed DMAS-351, with the attached appropriate documentation, must be submitted to:

Virginia Medical Assistance Program
P. O. Box 25507
Richmond, Virginia 23261-7444

Additional DMAS-351 forms may be obtained by contacting:

Commonwealth/Martin
1700 Venable Street
Richmond, Virginia 23223
Main Tel. #: (804) 780-1700
DMAS Order Desk Tel.#: (804) 780-0076
Fax: (804) 782-9876

Submission of Additional Information

If the DMAS preauthorization contractor has received a request and determined that additional information is necessary to complete the review process, the provider will be notified by telephone and/or will be mailed a "computer generated pend letter" identifying the specific information that is needed. The preauthorization contractor has the option of requesting additional information at its discretion. If submitting additional information via telephone, contact the preauthorization contractor directly.

If submitting additional information in writing, follow the instructions as indicated on the "computer generated pend letter" by attaching the completed DMAS-361 (6/03 version). (See "Exhibits" at the end of this chapter for a copy of this form and instructions for completion.)

It is the responsibility of the requesting provider to coordinate and submit the additional information that has been requested. Additional information must be submitted within 30 days of the date on the letter. If information has not been received within the allowed time period, the request will be rejected. If the requested service is rejected, but the authorization is still needed, a new "original" request must be submitted and all supporting documentation must be attached.

Packages or documents that are received and are not clearly identified will be discarded if they cannot be matched with the original request. When submitting written information in response to a pended request, attach the documentation to the properly completed DMAS-361 form and send to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261-7444

Handling of Rejected DMAS-351 Requests

Reject action codes (beginning with a "400") may be applied at several points during the review process either by the fiscal agent or by the DMAS preauthorization contractor. The preauthorization request may be rejected for various technical reasons (e.g., incomplete areas).

DMAS-351s (6/03 revision) that do not contain the requesting provider's nine-digit provider number or do not contain the provider number and the twelve-digit recipient identification number and the PA Service Type of 0500 will be rejected before entry into the system. There will be no record on the automated preauthorization file of these requests ever having been submitted.

Providers will be notified of other reject actions at the point in which the reject action code is applied. This information will be stored on the automated preauthorization file, and providers may inquire for preauthorization status by contacting the DMAS provider HELPLINE. Remember that the HELPLINE is for provider use only. Do not give the provider HELPLINE number to recipients.

Action reasons are applied to each service code being requested. If more than one service code is requested, the entire DMAS-351 package may contain multiple action codes (some codes/line items may be denied, others rejected, others pended for additional information, and others approved). Reject reasons applied automatically by the system at the fiscal agent's location are done so before the DMAS-351 package is forwarded to the DMAS preauthorization contractor for review. Service codes that pass all the system-generated reject and denial edits are forwarded to the preauthorization contractor for staff review. The preauthorization contractor will not review those service codes that have been denied or rejected by automated system edits.

Once the provider receives a reject reason for a requested service code, the provider must submit a new DMAS-351 (6/03 revision) package and indicate that it is an "original request" in order to have the service preauthorized. The new package must contain all necessary supporting documentation. The provider may not bill a recipient for covered services where the preauthorization packet is rejected with a reject reason code.

No alternate versions of the DMAS-351 (6/03 revision) may be used (such as computerized). Only the originals supplied by DMAS or photocopies will be accepted unless previously approved by DMAS.

All of the services requested on the DMAS-351 will be treated as one preauthorization request and will be assigned the same tracking number. This tracking number must be entered on the claim submitted for these items. Only one tracking number will be permitted for each claim.

PREAUTHORIZATION RECONSIDERATIONS AND APPEALS PROCESS

If services are denied by the preauthorization analyst and the home health provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a preauthorization request is denied, the provider may either request telephonic or written reconsideration from the DMAS preauthorization contractor Outpatient Review Services Supervisor within 30 days of the date of the denial. The DMAS preauthorization contractor Outpatient Review Services Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. If a written request is denied, the provider must submit a letter to the DMAS preauthorization contractor Outpatient Review Services Supervisor requesting reconsideration within 30 days of the notice of denial, to:

WVMI
Outpatient Review Services Supervisor
6802 Paragon Place
Suite 410
Richmond, Virginia 23230

If a denial is made due to failure to meet medical necessity criteria, a physician reconsideration may occur. After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of the denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.

HOME HEALTH SERVICES PROVIDER REQUIREMENTS

Physician Supervision and Certification

Recipients of home health services must be under the care of a physician who is legally authorized to practice and act within the scope of his or her license. If the recipient is enrolled in MEDALLION, the physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. This referral

may be obtained in writing or orally and must be documented in the recipient's record. The physician may be the recipient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the assisted living facility (ALF) which is the recipient's residence or, if the agency is hospital-based, a physician on the hospital staff.

If a specialist admits the recipient to home health, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

A written physician's statement, which may be on the home health certification plan of care/treatment, in the form of physician orders, in the medical record, must indicate that:

- The recipient needs licensed skilled nursing care, home health aide services, physical therapy, occupational therapy, or speech-language pathology services; and

- A plan for furnishing such services to the recipient has been established and is periodically reviewed and signed by a physician.

Subsequent physician home health recertification plans of care are required at intervals of at least once every 60 days. These recertifications must be signed and dated by the physician, who reviews the recertification, within 60 days of the start of the previous plan of care. DMAS will not reimburse the home health agency for services provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the start of the previous plan of care. The recertification plan of care must include, but is not limited to, all of the orders for start of previous plan of care services, including frequency and duration. The recertification plan of care must also include any orders obtained as a result of modifications to the previous plan of care, which remain in effect, and include updated goals and time frames for goal achievement for all services ordered.

The physician must approve modifications to any plan of care. These modifications may be in the form of a verbal order that is signed and dated by the physician. A verbal order that necessitates a change in the current plan of care must be signed and dated by the physician. The verbal order must be received by a registered nurse. If rehabilitative therapies are the only services ordered by the physician, a qualified licensed therapist may receive the verbal orders.

If a recipient is admitted to home health care before Medicaid eligibility is effective, the Medicaid enrollment date is considered the date of admission to services and will determine when the next certification is due.

Nursing Services

Nursing services may be provided by contract with a licensed registered nurse in geographic areas not covered by a licensed home health agency. It is the home health agency's responsibility to insure that the nurse is licensed by the Virginia Board of Nursing and meets all requirements as mandated by the Virginia Department of Health Professions.

There are three types of nursing visits:

- Initial assessment visit to admit the recipient into home health services, completed by a registered nurse, which involves an assessment of all of the recipient's health care needs.

- Routine follow-up visits in which a specific treatment/procedure or recipient/ caregiver education related to developed goals is performed. Some examples of routine follow-up visits are visits for:

  - Wound care where strict aseptic or sterile technique is required;

  - Periodic Foley catheter changes;

  - Post-hospital teaching sessions where the primary focus is to assist the recipient and/or caregiver in the transition of receiving extensive patient teaching to meet the recipient's medical needs in the home environment;

  - Pre-filling of insulin syringes no more than once every two weeks, unless the recipient's blood sugar instability warrants medically necessary changes in insulin dosages or the prescribed brand of insulin changes.

  - A routine follow-up visit is not a visit that would be done periodically over extended periods of time for general or non-specific goals. Examples of these types of visits are, but not limited to: periodic assessment of diabetic hypertensive or otherwise chronically ill recipients whose conditions have remained stable, and well-baby growth and development assessments on infants and children without current acute deficits or routine infant care teaching to parents. Visits made because of on-going social welfare limitations (e.g., protective services) do not constitute a routine, follow-up skilled nursing visit. These types of visits are not Medicaid reimbursable visits.

- The comprehensive skilled nursing visit criteria establish a set of conditions that must be met for a visit to be billed as a comprehensive skilled nursing visit and, therefore, reimbursed at the higher reimbursement rate. This set of conditions includes, but is not limited to:

  - High technology and extended lengths of time for the provision of the high-tech task;

  - Complex AND multidimensional situations requiring extensive skills in teaching the provision of extensive hands-on skilled care by qualified personnel. (All nurses must be trained in the technology of the science of nursing and have a degree of expertise. It is the responsibility of the agency to send a qualified nurse into the home. The credentials of the nurse are not the determining factor of Medicaid reimbursing at the comprehensive rate.)

"High-technology" refers to the complexity of procedures often involving the use of instruments, equipment and machines. At a minimum, supporting documentation in the form of physician's orders, plans of treatment, nursing care plans, and/or visit progress notes must clearly describe the following:

- The number and type of skilled procedures to be performed by the nurse during the visit;
- The number and complexity of steps needed to complete each procedure; and
- The extent to which the nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a physician, and/or adjust orders/plans of care.

NOTE: See Chapter VI for minimum documentation requirements for reimbursement at the comprehensive visit rate.

Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse and must meet Virginia licensing requirements for this supervision.

A registered nurse must make the evaluation visit to initiate home health services; regularly evaluate the recipient's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial and specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the physician and other personnel of changes in the recipient's condition and needs; educate the recipient and family in meeting nursing and related goals; and supervise and educate other personnel involved in the recipient's care.

The licensed practical nurse furnishes services according to agency policies; prepares clinical and progress notes; assists the physician and registered nurse in performing specialized procedures; prepares equipment and materials for treatments involving aseptic techniques as required; and assists the recipient in learning appropriate self-care techniques.

Home Health Aide Services

Home health aide services are intended to assist the recipient/caregiver during a period of time that a recipient is adjusting to a change in his or her ability to conduct activities of daily living. Additionally, home health aides can appropriately be utilized to assist in carrying out nursing or rehabilitative care plans. Home health aide services must be incorporated into an outcome-specific nursing care plan.

Home health aide services are not intended to be utilized for any services outside the specified qualifications. Examples of services which are not considered a part of the home health aide responsibilities are preparing or administering medications; administering nasogastric or gastrostomy tube feedings; and teaching or instruction to the recipient or caregiver. Home health aides must meet the qualifications specified by 42 CFR §484.36. The home health agency must maintain documentation which demonstrates that the home

health aides employed or contracted by the agency meet these required qualifications.

Home health aide services may include assisting with personal hygiene, eating, walking, meal preparation and feeding, and taking and recording blood pressure, pulse, and respiration. Written instructions for recipient care must be prepared by the registered nurse or licensed therapist as appropriate.

When it is identified that a recipient has an ongoing need for services similar to those provided by the home health aide, the home health agency must provide information to the recipient and/or caregiver about other services (e.g., personal care, companion aide, etc.) that may be more appropriate in meeting their needs. The home health agency is expected to make the necessary referrals for these services prior to utilization of the recipient's 32 allowable home health aide visits. Once other services similar to those provided by the home health aide begins, the home health aide services are to be terminated.

Supervisory Visits for Home Health Aide Services

Home health aide services must be provided under the supervision of a registered nurse or licensed therapist. When only home health aide services are being furnished, a registered nurse must make a supervisory visit to the patient's residence at least once every 60 days. Each supervisory visit must occur when the aide is furnishing care. The supervisory visit is not reimbursable by the Medicaid program.

When skilled nursing care or physical therapy, occupational therapy, or speech-language pathology services are also being furnished to the patient, a registered nurse must make a supervisory visit to the patient's residence at least every two weeks (either when the aide is present or when the aide is absent). When only a rehabilitative therapy is furnished in addition to the home health aide services, a skilled therapist may make the supervisory visit in place of a registered nurse. The supervisory visit is not reimburseable by the Medicaid program.

When supervisory visits are not provided in accordance with DMAS policy, DMAS will not provide reimbursement for the home health aide visits.

Rehabilitation Services: Physcial Therapy, Occupational Therapy and Speech Language Pathology Servcies

Physical Therapy

Physical Therapy services are those services provided to a recipient in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a physical therapist (PT) licensed by the Virginia Board of Physical Therapy (effective

9-27-2000). The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapist assistant (LPTA), who is licensed by the Virginia Board of Physical Therapy, under the direct supervision of a qualified licensed physical therapist, as defined above;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of services be reasonable.

Only a licensed PT has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed physical therapist (PT) are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapist assistant. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed physical therapist (not the LPTA). When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 days while therapy is being conducted and documented accordingly. When supervisory visits are not conducted in accordance with DMAS policy, physical therapy visits will not be reimbursed.

If an adequate number of qualified personnel are not available to carry out the physician order, the therapist must inform the physician of this and record the response of the physician in the recipient's medical record. The plan of care/treatment plan must be revised according to the physician's written approval. This revision may be obtained in the form of a physician signed and dated (verbal order is acceptable) to amend the home health certification plan of care/treatment or therapy plan of care.

Physical Therapy services may include the following:

Gait Training

Gait evaluation and training, provided to a recipient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality, require the skills of a licensed physical therapist and constitute physical therapy, provided that it can reasonably be expected to

significantly improve the recipient's ability to walk.

Examples of services that do not constitute rehabilitation physical therapy are:

- Activities appropriately provided by supportive personnel (e.g., aides or nursing staff); and
- Activities that do not require the skills of a licensed physical therapist or licensed physical therapy assistant.

Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specific diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the recipient, which may be performed safely and effectively only by a licensed physical therapist or licensed physical therapy assistant under the direct supervision of a therapist, will be considered rehabilitation physical therapy that is reimbursed.

Range of motion exercises not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.) and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. Passive exercises to maintain range of motion in paralyzed extremities can be carried out by physical therapy aides, home health aides, nursing staff or supportive caregivers and will not be considered rehabilitation therapy and, therefore, are not reimbursable visits.

Therapeutic Exercises

Therapeutic exercises (e.g., strengthening, stretching, tilt table activities, etc.), performed by or under the direct supervision of a licensed physical therapist, due to either the type of exercise employed or the condition of the recipient, constitute covered physical therapy and can be reimbursed.

Occupational Therapy

Occupational Therapy services are those services provided to a recipient in his/her place of residence that meets all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of practice under state law;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a registered and licensed occupational therapist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore or compensate for lost of function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a registered and licensed occupational therapist are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the registered and licensed occupational therapist (not the COTA). When services are provided by a COTA, the OTR must conduct a supervisory visit at least every 30 days and document accordingly. When supervisory visits are not conducted in accordance with DMAS policy, occupational therapy visits will not be reimbursed.

If an adequate number of qualified personnel are not available to carry out the physician order, the therapist must inform the physician of this fact and record the response of the physician in the medical record. The plan of care/treatment plan must be revised accordingly with the physician's written approval. This revision may be in the form of a physician signed and dated (verbal order is acceptable) to amend the home health certification plan of care or therapy plan of care.

Occupational therapy may involve some or all of the following:

- The evaluation and re-evaluation, as required to assess a recipient's level of function by administering diagnostic and prognostic tests that can be completed in a recipient's place of residence;

- The selection and teaching of task-oriented, therapeutic activities designed to restore physical function (e.g., use of woodworking activities to restore shoulder, elbow and wrist range of motion lost as a result of burns or other injury);

- The planning, implementing and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, assist with memory loss and reality orientation in a neurologically impaired recipient);

- The planning and implementing of therapeutic tasks and activities to restore sensory integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke recipient with functional loss resulting in a distorted body image); and

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a recipient who has lost the use of an arm dressing and cooking skills with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a spinal cord injured recipient new techniques to enable him or her to perform feeding, toileting, and other activities as independently as possible). Rehabilitation services shall be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services must be reasonable.

Speech-Language Pathology

Speech-language pathology services are those services provided to a recipient in his/her place of residence that meet the following conditions:

The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology. The *Code of Federal Regulations* (42 CFR § 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law.

The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by any one of the following:

- A Master's level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions and the Virginia Board of Audiology and Speech-Language Pathology; or

- An individual licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets one of the following:

  a) Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); or

  b) Has completed the Master's level academic program and is acquiring supervised work experience to qualify for the ASHA certification.

     This individual is in the Clinical Fellowship Year (CFY). This individual must be under the direct supervision of a licensed CCC/SLP or SLP. Direct supervision by a qualified therapist includes initial direction and periodic observation of the

actual performance of the therapeutic activity. When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document the visit in the recipient's record accordingly.

c) Effective January 1, 2001, DMAS will reimburse for the provision of speech-language services when provided by an individual identified as a speech-language assistant, e.g., Bachelor's level, a Master's level without licensure by the Board of Audiology and Speech Language Pathology, or a Master's level with licensure only by the Department of Education. The identity of the unlicensed assistant (and the fact he/she does not meet qualification requirements to bill Medicaid) shall be disclosed to the recipient, parent, or legal guardian prior to treatment, and this disclosure shall be documented and made a part of the recipient's record. These speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets provider licensure requirements.

Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP or a speech-language assistant, a licensed CCC/SLP or SLP must make a supervisory on-site visit at least every 30 days while therapy is being conducted. The supervisory therapist is not required to co-sign the speech-language assistant's progress visit notes; however, he or she is required to review the notes. If the supervisory therapist co-signs the assistant's progress visit notes, this does not constitute a 30-day supervisory visit note. Evidence of the supervisory therapist's on-site visit must be documented every 30 days in the recipient's record.

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a licensed speech-language pathologist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore or compensate for lost function, and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed speech-language pathologist are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan of may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, and speech-language assistants as identified above. The plan of care/treatement care plan must be developed and signed only by the licensed speech language pathologist.

If an adequate number of qualified personnel are not available to carry out the physician's order, particularly related to the frequency of service, the therapist will inform the physician of this fact and record the response of the physician in the medical record. The plan of care will be revised accordingly with the physician's written approval. This amendment to the home health plan of care may be obtained in the form of a written, verbal order including duration and frequency, as appropriate, that is signed and dated by the physician.

Speech-language pathology services include the following procedures:

- Assistance to the physician in evaluating recipients to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech-language pathologist of a recipient with aphasia following a recent stroke to determine the need for speech-language pathology services;

- Providing rehabilitative services for speech and language disorders;

- Providing rehabilitative services for swallowing disorders, cognitive problems, etc.

Guidelines for Initiating and Continuing Therapy

The following are guidelines designed to assist with the determination of appropriate services:

- DMAS will only reimburse for the specific therapy evaluation. A nursing evaluation is not required by DMAS and will not be reimbursed.

- **Maintenance Therapy** – Maintenance therapy is defined as the point where the recipient demonstrates no further significant improvement or the skills of a qualified rehabilitative therapist are not required to carry out an activity or home program to maintain function at the level to which it has been restored. Services in this category are not covered.

- **Improvement of Function** - Rehabilitation services designed to improve function must be based on an expectation that the therapy will result in a significant, practical improvement in a recipient's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is instituted, the services would be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the recipient is not going to improve or has reached his/her maximum rehabilitation potential. A home exercise program should be reviewed with the recipient and/or caregiver to maintain skills taught by the qualified therapist. At this point, home health therapy services should be terminated.

Discharge/Termination from Services

Rehabilitation services must be considered for termination regardless of the preauthorized length of services when any one of the following conditions are met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered therapist are no longer required for safe and effective provision of such rehabilitation services. The recipient has reached his or her maximum progress, and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the recipient or caregiver;
- The recipient has an unstable condition that affects his or her ability to participate in a rehabilitative plan of care/treatment plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; and

The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

Definition of a Visit

A visit is defined as the duration of time that a home health nurse, home health aide or rehabilitation therapist is with a recipient to provide covered physician-ordered services in the recipient's place of residence. Visits are not defined in measurements or increments of time. The furnishing of any services by a particular qualified nurse, therapist or home health aide on a particular day or particular time of day constitutes a visit. For example, if both a physical therapist and/or an occupational therapist furnish services on the same day, this constitutes two visits. However, if a therapist, nurse of home health aide furnishes several services during a visit, this constitutes only one visit for each discipline that furnishes services. If a therapist, nurse or home health aide provides two distinctly separate therapy sessions/services in the same day (e.g. morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist, nurse or home health aide cannot be billed as separate visits if the goals are the same for that visit by a particular discipline (e.g. two therapists, nurses or home health aides are required to perform a single procedure or are working collaboratively toward the same goal). The overall goal(s) of the session determines how the visit can be billed.

SERVICES FOR RECIPIENTS IN ASSISTED LIVING FACILITIES (ALFs)

Limited home health coverage is available for recipients in an assisted living facility (ALF). ALFs must provide for certain services as mandated by the Department of Social Services (DSS) licensing standards for ALFs. When the ALF must provide home health nursing or aide services as a component of these covered services, DMAS shall not reimburse a home health agency to provide such services to residents of ALFs. The ALF must provide the

services as specified below, and the home health agency cannot bill DMAS for any of the specified non-reimbursable services. These services are:

- Home health aide services;
- Medication administration including, but not limited to:
  - By-mouth (oral) administration
  - Insulin injections
  - Eye drops
  - Rectal administration
  - Topical application
  - Inhalers, and
  - Nasal administration;
- Medication monitoring; and
- Superficial wound care for pressure ulcers up to stages I to II or care to skin tears, minor cuts, or abrasions.

When injections other than insulin are necessary and ordered by the physician, the ALF must either administer the injection by appropriately licensed staff or assist the resident by securing the injection services through a home health agency, through an outpatient clinic visit, or through emergency services as most appropriate for the medical circumstance and reimbursement guidelines.

If a home health provider bills for or has billed for any of these services for a resident of an ALF, DMAS will deny or retract reimbursement for the inappropriate payments for such services.

Medicaid may cover skilled nursing services provided by a home health agency. These cases only include services the ALF is not required to provide. Personal care/ADL services provided by a home health agency will not be reimbursed. If skilled nursing services have been utilized for over 30 days, a change in the resident's cognitive or functional ability may have occurred. The ALF should notify DMAS within two weeks of the resident's receiving 30 days of skilled nursing services. The resident's change in cognitive or functional ability may warrant an assessment as to whether the resident is receiving the appropriate level of care. The *Virginia Administrative Code* (22 VAC 40-71-150) prohibits ALFs from admitting or retaining individuals with any of the following conditions:

1. Ventilator dependency;
2. Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing;
3. Intravenous therapy or injections directly into the vein except for intermittent therapy managed by a health care professional licensed in Virginia when it is on a time-limited basis under a physician's treatment plan;*

4. Airborne infectious disease in a communicable state, including diseases such as tuberculosis and excluding infections such as the common cold;

5. Psychotropic medications without appropriate diagnosis and treatment plans;

6. Nasogastric tubes;

7. Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube; *

8. Individuals presenting an imminent physical threat or danger to self or others;

9. Individuals requiring continuous, licensed nursing care;

10. Individuals for whom his or her physician certifies that ALF placement is no longer appropriate;

11. Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the Uniform Assessment Instrument (UAI) and meet Medicaid nursing facility level of care criteria as defined by the *State Plan for Medical Assistance*. Maximum physical assistance means an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI; and

12. Individuals whose health care needs cannot be met in the specific ALF as determined by the residence.

* For those individuals who do not receive the auxiliary grant payment, at the request of the resident, and pursuant to regulations of the Department of Social Services, care for the conditions or care needs defined in Sections 3 and 7 above may be provided to a resident in an ALF by a licensed physician, a licensed nurse under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Supplies and equipment (e.g., gauze, cotton, adhesive bandage, sphygmomanometer, scales, etc.), which are used during the course of the home visit by personnel of the home health agency, are included in the visit fee paid to the agency. The only supplies for which the provider of supplies may receive separate reimbursement are those supplies that remain in the home beyond the time of the visit to allow the recipient to continue treatment.

Intravenous Therapy Supplies

Nursing visits for Intravenous (I.V.) Therapy are reimbursed under home health services. To receive reimbursement for I.V. Therapy Nursing Services, the provider must be a Medicaid home health provider with a valid home health Medicaid provider number. The home health visit reimbursement for all nursing services includes, but is not limited to,

travel time, recipient education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the durable medical equipment (DME) service day rate allowance to whichever DME provider furnishes the supplies.

TRANSPORTATION

Extraordinary transportation costs to and from the recipient's home may be recovered by the home health agency if the recipient resides outside of a 15-mile radius of the home health agency. An add-on fee will be paid for miles traveled per day per independent staff member in excess of a 15-mile radius from the home health agency. Mileage will be calculated from the radius to the farthest point of travel per day and return to the point of radius. Payment will be set at a rate per mile as established by the General Services Administration in the "Federal Travel Regulations," which is published in the *Federal Register*, times the excess mileage over the 15-mile radius.

If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made, regardless of the number of miles driven by the staff member. Mileage charges should be added to the invoice of the recipient who lives the farthest point of travel for the day. The home health agency must keep daily mileage records of staff and have available a map that identifies a 15-mile radius. For a home health agency to receive reimbursement for transportation, the recipient must be receiving Medicaid home health services.

NON-COVERED SERVICES

The following services are not covered:

- Medical social services;
- Services or items which would not be paid for if provided to an inpatient of a hospital or nursing facility, such as private-duty nursing service, or items of comfort which have no medical necessity, such as a television;
- Meals on Wheels or similar food service arrangements;
- Domestic or housekeeping services which are unrelated to recipient care and which materially increase the time spent on a visit;
- Custodial care which is recipient care that primarily requires protective services rather than definitive medical and skilled nursing care;
- Skilled home health nursing and home health aide services when the individual is enrolled for comparable services available under one of the home and community-based waivers;

- Home health nursing or aide services for residents of ALFs if the residence is responsible for providing the services as a component of the covered services governed by the Department of Social Services licensing standards for ALFs;
- Multiple visits when there is no break in services on a given day or multiple disciplines providing a single procedure or working collaboratively toward the same goal;
- Services which fall under the category of psychotherapy;
- Maintenance therapy;
- Services which fall under the category of private duty nursing; and
- Services related to cosmetic surgery.

COPAYMENTS FOR HOME HEALTH RECIPIENTS

The copayment for home health recipients is limited to one $3.00 charge per day. It is important that providers use care in billing for overlapping dates of service. A copayment is applicable for each date of service; however, as the invoice does not show the specific dates of service when a range of days is billed, claims processing applies certain assumptions in calculating copayments. The primary assumption is that a copayment is taken based on the lesser of the number of days indicated by the from/through days or the number of visits for a single procedure code on the claim. Providers should use care to accurately reflect the number of days (encounters) of direct patient care. Only one copayment is applicable for each day (encounter) per provider type for a recipient regardless of the number of services being provided.

DMAS will calculate the copayment by multiplying the copayment amount ($3.00) by the number of days listed in Locator 7, which is a required field on the invoice. Home health claims will be rejected if (a) Locator 7 is blank; (b) the total days exceed the number of days between the from and through dates; or (c) the total days exceed the number of services. The amount of the copay will be deducted from the provider's reimbursement.

EXHIBITS

TABLE OF CONTENTS

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

Page ____ of ____

SERVICING PROVIDER INFORMATION

Number: 4

Name: 5

Contact Person: 6

Phone: 7

Enrollee ID# : 8

Enrollee Name:

Last: 9

First: 10

MI: 11

Referring Provider # 12

13 ☐ Other Non-Paper Enclosure

14 ☐ X-Rays Enclosed

15 ☐ Photographs Enclosed

Diagnosis Code: 16

PA Number: 17 (If cancellation or change)

PA Service Type: 18

1	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
2	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
3	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
4	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
5	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		
6	19 ☐ HCPCS/CPT 20 ☐ Revenue Code 21	22 Modifiers (If Applicable)	Units Requested: 23 Amount Requested: 24	Desc: 25	Line # (If Requesting Cancellation Or Change) 26
	Dates of Service Requested (MM/DD/YY) From: 27		To: 28		

FOR ADDITIONAL PROCEDURES FOR THE SAME PA #, USE AN ADDITIONAL FORM -
ENTER BOXES 4, 5, 12, 13, 14, AND 15 ON EACH ADDITIONAL FORM

29 Provider Signature: _____ 30 Date Signed: _____

DMAS - 351 R 6/03

Instructions For Completion of the DMAS 351 – Virginia Department of Medical Assistance Services "Prior Review and Authorization Request" Form

The DMAS 351 is to be used when requesting a new prior authorization, to request a change an existing authorization, or to cancel an existing authorization. Note: A cancellation request can only be honored if there has been no claims activity posted against the authorization.

HEADER DATA

1 – 3	Put an "X" in the box next to the type of request being submitted.
4 – 7	Servicing Provider Information: includes provider ID #, name, , a contact person's name, and telephone number.
8 – 11	Enrollee (Patient) Information: includes enrollee ID#, last name, first name, middle initial.
12	Referring Provider ID # (if applicable).
13 – 15	Indicate if attaching a non-paper enclosure, x-ray, or photograph for review.
16	Enter the primary diagnosis code for the enrollee.
17	Enter the PA Number (tracking number) if requesting a change or cancellation.
18	Enter the appropriate PA Service Type. (See listing in Provider Manual with these instructions.

LINE ITEM DATA

Each form will accommodate up to 6 lines of requests for authorization of services or equipment. If more than 6 lines are needed, use additional DMAS-351's to request additional services or equipment. Be sure to indicate the number of the pages being submitted (top right), especially if more than one DMAS-351 is required.

19 – 25	Indicate the type of procedure code, the procedure code, up to 4 modifiers (if applicable), the number of units requested, amount requested, and a description of the item/service requested.
26	Enter the line # for which you are requesting a change or cancellation.
27 – 28	Enter the From Date and To Date of Service
29 – 30	Provider's signature and date signed.

ATTACHMENTS

Attach required and supportive medical documentation to the completed DMAS-351 and submit to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation
2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA # (if known)
3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐	Line 6 ☐
Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐	Line 11 ☐	Line 12 ☐
Line 13 ☐	Line 14 ☐	Line 15 ☐	Line 16 ☐	Line 17 ☐	Line 18 ☐

PROVIDER INFORMATION

Number: 5 _____

Name: 6 _____

Contact Person: 7 _____

Phone: 8 _____

Enrollee ID# : 9 _____

Enrollee Name:

Last: 10 _____

First: 11 _____

MI: 12 ☐

13 ☐ Other Non-Paper Enclosure
14 ☐ X-Rays Enclosed
15 ☐ Photographs Enclosed
16 ☐ Dental Models Enclosed

PA Service Type: 17 _____

18 COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE, ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

19 Provider Signature _____ 20 Date Signed _____

DMAS - 361 R 6/03

Instructions For Completion of the DMAS-361
Virginia Department of Medical Assistance Services
"Prior Review and Authorization Request Supporting Documentation"

The DMAS-361 is to be used when returning requested documentation in response to a pend, to request reconsideration of an adverse prior authorization decision, or if sending in orthodontic models separate from the prior authorization request. This form and applicable attachments should be submitted to:

Virginia Medical Assistance Program
P.O. Box *25507*
Richmond, VA 23261

INSTRUCTIONS BY INDICATOR NUMBER:

1. Return Pend Documentation: Mark with an "X" if returning documentation in response to a pend.

2. Request for Reconsideration: Mark with an "X" if requesting reconsideration in response to an adverse prior authorization decision.

3. Pending or Denied PA#: Enter the PA or Tracking Number (if known). If sending in orthodontic models for authorization, leave this field blank.

4. Check appropriate box(es): Identify which line(s) of the Prior Authorization to refer to.

5. Provider Number: Enter the provider's Medicaid ID *#.*

6**.** Name: Enter the provider's name.

7. Contact Person: Enter a Contact's name representing the provider.

8. Phone: Enter the telephone number at which the Contact can be called.

9. Enrollee ID #: Enter the enrollee or *patient's* Medicaid ID *#.*

10—12 Enrollee Name: Enter the enrollee for patient's last name, first name and middle initial.

13—16 Enclosure Type: Enter an "X" in the appropriate box to indicate enclosure type.

17. PA Service Type: Enter the appropriate PA Service Type. (See listing in provider manual.)

18. Comments: Enter any comments that provide clarification or further information.

19. Provider Signature & Date The provider must sign and date the form.